

PRESCRIBER'S MEDICATION ORDERS IN _____ PARISH SCHOOLS

STUDENT: _____ **DATE OF BIRTH** _____

LICENSED PRESCRIBER: _____ **OFFICE PHONE:** _____

BUSINESS ADDRESS: _____ **EMERGENCY PHONE:** _____

Whenever possible, medication should be scheduled at times other than school hours. NEW ORDERS REQUIRED at the beginning of each school year, and whenever there is a change in the medication, dosage or time given at school.

Diagnosis: _____

Medication (one per page): _____

Dosage (at school): _____ **Route:** _____

Time to be given at school: _____ **Frequency:** _____

Desired Effect: _____

DATE OF ORDER: _____ **DISCONTINUE DATE:** _____

Trained unlicensed personnel may give oral medications, premeasured inhalants, topical ointment for diaper rash, and emergency medications at school. THE USE OF UNIT DOSE PACKAGING IS STRONGLY ENCOURAGED.

1. LIST OF CONTRAINDICATIONS TO THIS MEDICATION OR POTENTIAL ADVERSE EFFECTS SPECIFIC TO THIS STUDENT: _____

2. LIST OF OTHER MEDICATION (S) BEING TAKEN BY THIS STUDENT: _____

3. LIST OF OTHER MEDICAL CONCERN (S): _____

4. COMMENTS/OTHER INSTRUCTIONS: _____

USE THIS SPACE ONLY FOR STUDENTS WHO WILL REQUIRE MEDICATIONS ON OR NEAR THEIR PERSON FOR EMERGENCY SITUATIONS ONLY, SUCH AS STUDENTS USING AN ASTHMA INHALER OR EPI-PEN.

It is necessary for this student to keep his/her medication with them at all times. YES _____ NO _____

THIS STUDENT HAS BEEN ADEQUATELY INSTRUCTED BY MY STAFF AND DEMONSTRATED COMPETENCE IN SELF-ADMINISTRATION OF THIS MEDICATION TO THE DEGREE THAT HE/SHE MAY SELF-ADMINISTER AND MANAGE HIS/HER MEDICATION AT SCHOOL.

Signature of Authorized Prescriber

Physician's Stamp

ONE MEDICATION PER FORM